Community Score Card:

MAHEFA's innovative approach for improving the quality of community health services

Madagascar Community-Based Integrated Health Program (CBIHP), locally known as MAHEFA, was a five-year (2011-2016), USAID-funded community health program that took place across six remote regions in north and north-west Madagascar (Menabe, SAVA, DIANA, Sofia, Melaky, and Boeny). The program was implemented by JSI Research & Training Institute, Inc. (JSI), with sub-recipients Transaid and The Manoff Group, and was carried out in close collaboration with the Ministry of Public Health, the Ministry of Water, Sanitation and Hygiene, and the Ministry of Youth and Sport. Over the course of the program, a total of 6,052 community health volunteers (CHVs) were trained, equipped, and supervised to provide basic health services in the areas of maternal, newborn, and child health; family planning and reproductive health, including sexually transmitted infections; water, sanitation, and hygiene; nutrition; and malaria treatment and prevention at the community level. The CHVs were selected by their own communities, supervised by heads of basic health centers, and provided services based on their scope of work as outlined in the National Community Health Policy. Their work and the work of other community actors involved with the MAHEFA program was entirely on a voluntary basis.

This brief is included in a series of fifteen MAHEFA technical briefs that share and highlight selected strategic approaches, innovations, results, and lessons learned from the program. Technical brief topics include *Behavior Change Empowerment, Community Radio Listening Groups, Community Score Card Approach, Chlorhexidine 7.1%/ Misoprostol, Champion Communes Approach, Community Health Volunteer Mobility, Emergency Transport Systems, Malaria, Community Health Volunteer Motivation, Family Planning & Youth, WASH, eBox, Community Health Financing Scheme, Information Systems for Community Health and NGO Capacity Building.*

Background

The Community Score Card (CSC) approach solicits direct feedback from service users and initiates a dialogue between users and health service providers. The CSC approach allows communities and local health care providers to work together to improve services. Compared to other social accountability tools, the CSC approach requires little to no technology and is easily replicable for larger scale implementation. Unlike traditional administrative monitoring systems, the CSC method directly involves community actors and focuses on rapid local public disclosure of feedback versus a lengthy centralized process. The CSC requires sharing information with users on service norms and on aspects of service they can work with providers to improve. In some cases, it may promote an element of competition as it can involve comparing the performance of service from different providers[1]. The MAHEFA program used the CSC approach and tool to improve the quality of health services provided by 6,052 community health volunteers (CHVs) in its six program regions.

MAHEFA Context

CSCs in Madagascar began in 2007 by World Bank supported projects such as the *Programme de Réformes pour l'Efficacité de l'Administration (PREA)* and the *Projet de Gouvernance et Developpement Institutionnel (PGDI)*. They involved close collaboration with the Ministry of Health (MOH). CHVs played a vital role in providing health services in Madagascar, especially in remote regions where government health services were limited. MAHEFA built the capacity of CHVs to address a variety of health topics including but not limited to family planning, reproductive health, nutrition, and water, sanitation, and hygiene. To improve their service quality and advance the World Bank recommendations, MAHEFA pioneered the CSC approach with CHVs in the six program regions. This was the first time that the CSC approach was used among CHVs in Madagascar.

The MAHEFA Approach

MAHEFA began it's pilot in 2013 by using focus group discussions to gather information on health service performance. Focus group discussions were useful in that they provided more details about a community's response to services, however, they required a lot of resources and extensive organization. In 2015, MAHEFA introduced individual interviews in addition to focus group discussions. This technique provided similar information and was less expensive because interviews were conducted at the same time as routine supportive supervision visits. By the end of the program, MAHEFA decided using both CSC methodologies in all of it's six regions was the best and most effective approach to improving community health service quality.

1. *The World Bank, 2008. Scale-up of the Community Score Card Process in the Madagascar Health Sector. Discussion Draft, November 20, 2008*

Key Activities

1. Adapted the CSC methodologies and tools for use at the community-level. For the first half of 2013, the MAHEFA team analyzed the technical possibility of implementing the CSC approach in the program's intervention areas. This included feasibility studies and pilot projects, which resulted in the development of community-based tools and indicators. The Menabe, Sofia and DIANA regions were selected for pilot projects because among the MAHEFA intervention areas, they had the largest number of *fokontany* (a collection of villages) and highest number of CHVs.

2. Identified best approaches from the pilot phase and expanded CSC to other MAHEFA regions. After the pilot phase, MAHEA modified the CSC tool and trained over 300 field staff (MAHEFA and NGO partners) on how to conduct CSC focus group discussions and how to report data. The focus group discussions were organized by NGO field staff while MAHEFA team facilitated the discussions. The CSC approach was expanded to all of the MAHEFA's six regions. The discussions took place in two parts and separate discussions were organized amongst CHVs and community users. The CHVs completed a self-evaluation based on the 11 indicators. The community users evaluated the quality of CHV services based on the 11 indicators (Box 1). Then, the two groups met and shared their findings. From this combined group discussion, an action plan was developed to address all the weak areas identified by both groups. These discussions took approximately half a day and included 8-12 people. The frequency of CSC focus groups varied from community to community. However, the MAHEFA program staff recommended that discussions should be held every six months.

Box 1. Eleven CSC Indicators

MAHEFA selected 11 CSC indicators that were used by CHVs, service providers, and the community (potential users of CHV services). Two indicators were obligatory for all *fokontany* whereas the other nine varied by each *fokontany's* unique needs. The eleven indicators are listed below.

During CSC sessions, at the focus group discussion and individual interview levels, participants are required to discuss four indicators. The first two are the obligatory indicators mentioned above, and the last two are indicators that the community feels are most important at that point in time. Therefore the last two indicators change with every CSC session.

1) Availability of CHVs to provide services
2) Cleanliness of *toby* and storage area
3) Quality of infrastructure (availability of latrines, disposal pits etc.)
4) Level of transparency in the management of the site (costs, working hours)
5) Quality of the relationship between providers and users
6) Level of participation from the community in the development of the site
7) Quality of relationship between CHVs, CSBs, and community leaders
8) Availability and diversity of drugs and health supplies
9) Cost of services or drugs
10) Quality of education sessions conducted by CHVs
11) Quality of care and counseling offered by CHVs

3. Conducted an internal review and modified CSC methodology and tools. In 2014, MAHEFA conducted an internal review of its CSC approach. The internal review identified two major blockages in the implementation of the CSC focus group approach. The approach required intensive resources and depended heavily on the external team i.e. NGO staff. In many communities where the NGO field team did not follow the CSC work plans, the CSC activities were not carried out as previously discussed. To respond to this, the MAHEFA team provided regular follow-up visits to make sure that NGO staff carried out the agreed upon work plan and added individual interviews to the CSC methodology.

4. Implemented two CSC methods in all MAHEFA regions. After the review in late 2014, MAHEFA decided to incorporate two CSC methodologies in all program regions. The focus group discussions were conducted in selected *fokontanys* in each region, while the CSC individual interviews were conducted on a monthly basis by both NGO field staff and the community leaders. During the Champion Commune reviews, each *fokontany* leader presented their CSC results for both approaches and shared how they and all the stakeholders in their communities would address the poor quality services.

Results

At the end of the MAHEFA program, 1,866 *fokontany* conducted CSC focus group session once, 290 *fokontany* had carried out sessions twice and 39 *fokontany* carried out session three times or more. Additionally, 8,170 CSC individual interviews were conducted in 2,828 *fokontany*.

The CSC process helped identify the number of permanent working sites for CHVs. These sites, called *tobys* or health huts, were important hubs for CHVs to work at and provide services from on a regular basis. The community was responsible for maintaining these sites for CHVs in return for CHVs providing their services for free. The CSC focus group methodology helped

Figure 1. Achievements of CSC action points by the community as a result of the CSC focus group methodology by the end of February 2016

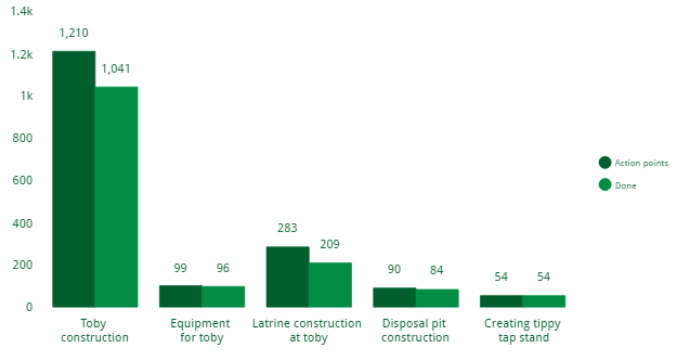
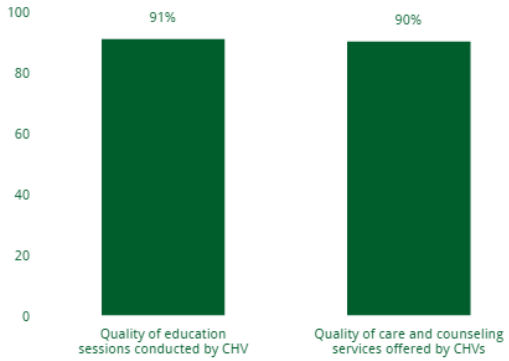


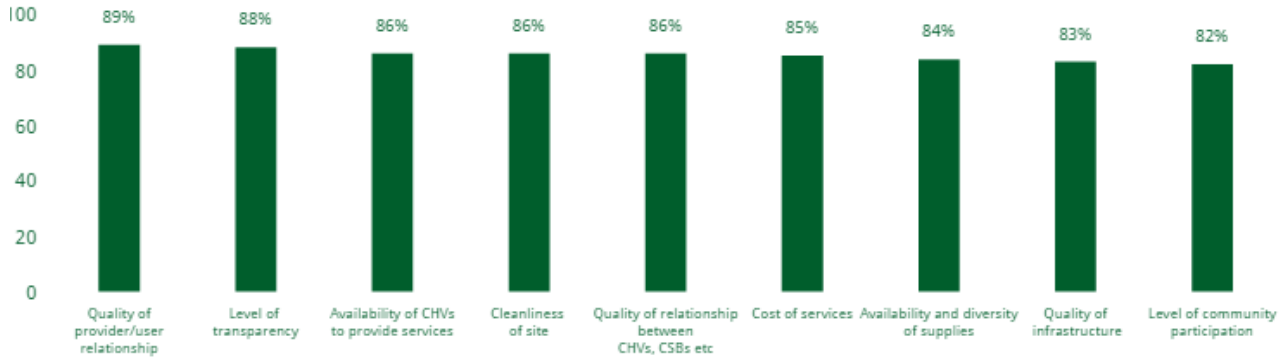
Figure 2. Satisfaction rate for two obligatory CSC Indicators (n=47,896)



CHVs and community members understand the importance of this mutualistic relationship and therefore encouraged the community to fulfil their responsibility to the CHVs in order to continue to receive CHV services. Figure 1 shows the achievements of the action points related to construction and maintenance of CHV *tobys*.

Figure 2 and 3 represent results from the CSC individual interviews related to the level of satisfaction from the users. Over 90 percent of the community members responded to this type of CSC method. Figure 2 shows that many members of the community were pleased with the quality of CHV education sessions and the quality of care and counseling they received from CHVs. Similarly, Figure 3 shows a high level of satisfaction (above 80 percent) in all other CSC Indicators.

Figure 3. Satisfaction rate for nine elective CSC interview indicators



Challenges

The concept and mechanism of the CSC approach among CHVs was new to Madagascar and the program regions, therefore it was not yet well understood by all individuals who conducted the activities at the community level. This resulted in lower commitment from field staff and community members to conduct the CSC activities. Furthermore, this made follow-up of the community action plan hard to reinforce. Lastly, this resulted in low reporting rates of the CSC activities.

The CSC activities were introduced by MAHEFA during a period in which the program was not authorized to work with the public sector. Therefore, the local health committees (*Comité de Santé* or COSAN and *Commission Communale du Développement de la Santé* or CCDS) were not able to receive training to develop the skill set needed to facilitate the CSC focus group discussion approach.

The CSC focus group model requires human, financial, and material resources that may make this activity difficult for a community to sustain on its own. The focus group model requires a skilled facilitator, supplies, and a minimum of eight participants. These factors could make focus groups difficult for communities to maintain.

In some cases, the methodology and tools did not completely respond to community need and context because the community did not have full leadership and ownership of the approach. The MAHEFA program relied on NGO implementing partners to facilitate and organize the focus group sessions. This removed the ownership and responsibility of the community leaders in this activity.

The CSC individual interview technique was introduced only in the last year of the program. As a result, there was not enough time to see its impact. Additionally, the COSANs did not have enough time to fully develop the commitment and skills necessary to continue the CSC activities on their own.

Lessons Learned and Recommendations

Plan the introduction of both methodologies at program inception. The two CSC methodologies can be complementary but they should be explained and planned at program inception to avoid confusion among the community. The CSC focus group technique allows a broader mobilization and promotes immediate collective decision making. The CSC individual interview method offers more privacy to users but delays the collective decision making process. However, this method can demobilize the community and hinder progress towards designing an action plan. Additionally, it lacks the important component of having face-to-face meetings between beneficiaries, CHVs and local authorities to develop the community action plan.

Incorporate both focus group discussions and individual interviews as part of the CSC approach. Confidentiality is a key element to the CSC interview. Some community members expressed their preference for the CSC focus group because they had the opportunity to hear the ideas and opinions of others, but they also appreciated the CSC individual interview because it allowed them to speak more freely.

Introduce the CSC approach to the community for the first time by using the focus group methodology. This methodology helps raise awareness on community health and the roles of CHVs. The subsequent methodology could then be a CSC interview because these *fokontany* have already participated in a face-to-face meetings to mobilize the community around the needs expressed by users and service providers.

Train and coach the local health committee members and CHVs on the CSC concept, methodology and tools to carry out the CSC approach. One of the most important aspects of the CSC process is that the communities develop an action plan to improve poor performing health indicators. This calls for a commitment from both the CHVs and COSAN members to develop the action plan and report progress on activities to CCDS at the commune (the smallest territorial division as defined for administrative purposes) level.

FOR MORE INFORMATION, PLEASE CONTACT:

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